No. 90-1684

Supreme Court, U.S.
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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1990

ROBERT P. BREWER, Natural Guardian and Duly-Appointed Next Friend of ROBERT C. BREWER,
*Petitioner*,

v.

LINCOLN NATIONAL LIFE INSURANCE CO.,
*Respondent.*

**On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit**

## PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

This case involves the standard for interpretation of ambiguous terms in an "employee welfare benefit plan" under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, et seq. At issue is the proper interpretation under ERISA of the terms "mental illness" and "psychiatric care," when those terms are used but not defined in a group health insurance policy. Resolution of this issue will determine whether the several million victims of bipolar affective mood disorder, also known as manic depression, an organically based physical dysfunction caused by a chemical imbalance in the brain, are entitled to coverage under the "major medical" provisions of most health insurance policies or instead are limited to the vastly reduced benefits payable under separate "mental illness" provisions.

### I.

The first question presented is whether ERISA nullifies the decisional law of all fifty states and the District of Columbia, the contra insurer rule, which regulates insurance by requiring that ambiguous terms in health insurance policies -- in this case, the terms "mental illness" or "psychiatric care" -- be construed in favor of the insured participants and beneficiaries and against the insurer.

### II.

If Missouri's contra insurer rule is nullified by ERISA, the second question presented is whether the federal common law of ERISA should adopt or incorporate the contra insurer rule, so that ambiguities in health insurance plans subject to ERISA will be construed in favor of the insured participants and beneficiaries of the plan and against the insurer.

## LIST OF PARTIES

In the proceeding below Robert P. Brewer, natural guardian and duly-appointed next friend of Robert C. Brewer, and the Lincoln National Life Insurance Company were the only parties. The Health Insurance Association of America, however, appeared before the Eighth Circuit as amicus curiae in support of Lincoln National Life Insurance Company.

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*Respondent.*

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# PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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Robert P. Brewer, natural guardian and duly appointed next friend of Robert C. Brewer, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

## OPINIONS BELOW

The opinion and judgment of the Court of Appeals (App. A, *infra*, A-1 to A-7) is reported at 921 F.2d 150. The opinion of the district court, (App. B., *infra*, A-8 to A-21) is reported at 730 F. Supp. 292.

## JURISDICTION

The opinion and judgment of the Court of Appeals were entered on December 7, 1990. On February 23, 1991 this Court extended the time for filing a petition for writ of certiorari to and including April 8, 1991. On March 29, 1991 this Court further extended the time for filing a petition for writ of certiorari to and including May 3, 1991.

Petitioner seeks this Court's review pursuant to 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

29 U.S.C. § 1144(a) provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 1003(a) of this Title and not exempt under Section 1003(b) of this Title.

29 U.S.C. § 1144(b)(2) provides:

> (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this Title, which is not exempt under section 1003(b) of this Title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

## STATEMENT OF THE CASE

*1. Introduction.* The issues in this case affect millions of people who have bipolar affective mood disorders, also known as "manic depression." Persons with such disorders have been forced to bear health insurance benefit reductions or denials, based on interpretations of unclear and ambiguous policy language by insurers that have wrongly classified these disorders as "mental illnesses." *See* Brief Of National Depressive And Manic Depressive Association As Amicus Curiae In Support Of Petition Of Robert P. Brewer For Writ Of Certiorari. Both of the questions presented by this petition raise the issue of whether the contra insurer rule -- the rule of every state and the District of Columbia which holds that ambiguous terms in an insurance policy are construed in favor of the insured and against the insurer -- applies to a health insurance policy governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974), *codified at*, 29 U.S.C. § 1001 et seq. (1986) ("ERISA").

Petitioner contends that respondent's insurance policies contained the ambiguous terms "mental illness" and "psychiatric care." Those terms were undefined in successive group health insurance policies, that were purchased from respondent by petitioner's employer for the benefit of

petitioner and other employee participants and beneficiaries. App. B at A–10 to A–12, 730 F. Supp. at 293–94. Under the pertinent insurance policies "psychiatric care" and other treatment of a "mental illness" was excluded from respondent's liberal "major medical" policy coverage. Instead, respondent's insurance policies allowed coverage for such treatment only to the extent of significantly reduced "mental illness" benefits. App. B at A–10, 730 F. Supp. at 293.

Resolution of the ambiguity in the applicable policy depends on whether the term "mental illness" should be defined by the diagnostic *cause* of the illness or the manifested *symptoms* thereof. Likewise, resolution of the ambiguous term "psychiatric care" depends on whether the term relates to any treatment which *necessarily* must be done or directed by a psychiatrist as treatment for a "true" mental illness, as opposed to any treatment *merely rendered* by a psychiatrist regardless of the nature and etiology of the underlying problem. A classification of "mental illness" based on *symptoms* leads to a much broader exclusion from coverage under almost all health insurance policies than does a classification based on the *cause* of the disorder. Likewise, a classification of "psychiatric care" based on whether a psychiatrist *happened to provide* the treatment leads to a far greater exclusion of treatments from major medical coverage than would a classification based on whether the treatment *necessarily* had to be ordered by a psychiatrist.

Petitioner's son, Robert C. ("Rob") Brewer, suffered from affective mood disorder, an illness with symptoms such as mood swings and depression that can be symptomatic of mental illness. App. B at A–13 to A–15, 730 F. Supp. at 294–295. Nevertheless, as the evidence at trial showed (and which the appeals court ignored), the illness is caused not by

environmental[1] effects, but instead by an organically based dysfunction that arises from a chemical imbalance in the brain. App. B at A-13 to A-16, 730 F. Supp. at 295-96. Generally, organically caused illnesses, such as brain cancer and Alzheimer's disease, have not traditionally been categorized as "mental illnesses" even though they affect the brain. App. B. at A-19 to A-20, 730 F. Supp. at 297-98. How a particular disorder is classified determines whether health insurance companies like respondent pay full "major medical" benefits, rather than the vastly reduced benefits payable under "mental health" or "mental illness" provisions. *See* App. B at A-21, 730 F. Supp. at 298 (full benefits for "affective mood disorder" when "mental illness" classified by cause). *Cf.* App. A at A-7, 921 F.2d at 154 (reduced benefits for same disorder when "mental illness" classified by symptoms).

Similarly, although psychiatrists frequently treat bipolar affective mood disorder, they need not necessarily do so. An internist or family practitioner is also qualified to treat the illness by drug therapy. Trial Transcript at 123-24, 126, 144. Accordingly, another issue under the policy is whether the exclusion that provides reduced benefits for "psychiatric care" is limited to treatment that *only* a psychiatrist could have provided, or instead includes treatment that *could* have been provided by an internist or family practitioner.

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[1]As used in this petition, an "environmental" cause of mental illness relates to "traumatic experiences or childhood relationships" or other such behavioral causes. App. B at A-19 to A-20, 730 F. Supp. at 297-98 (quoting *Kunin v. Benefit Trust Life Ins. Co.*, 696 F. Supp. 1342, 1347 (C.D. Cal. 1988)). As thus defined, a behavioral, "environmental" cause of an illness is to be distinguished from a physical, organically based, "environmental" cause of mental illness, such as lead poisoning or over-exposure to industrial chemicals.

*2. Proceedings in the District Court.* Petitioner filed suit in the United States District Court for the Eastern District of Missouri to challenge respondent's exclusion from coverage of certain claims made by petitioner under a group health insurance policy and a successor policy that constituted employee welfare benefit plans under ERISA. Petitioner was a covered "participant" under the plans and his son was a beneficiary. After a one-day bench trial the district court, the Honorable William L. Hungate, Judge, issued findings of fact and conclusions of law.

Petitioner's son was hospitalized and treated on three occasions for "severe affective mood disorder." App. B at A-13, 730 F. Supp. at 294. The parties stipulated that the charges for these hospitalizations were reasonable and that the treatment rendered was reasonably necessary to treat the son's condition. *Id.* The parties further stipulated that the disputed charges would fall within and be fully paid under the "major medical" policy provisions, but for their exclusion under the "mental illness" provisions of those same policies.[2] App. B at A-10, 730 F. Supp. at 293.

The policy exclusions from "major medical" coverage for "mental illness" were written differently in each policy, and in both policies the term "mental illness" was not defined. App. B at A-11, A-12, 730 F. Supp. at 294. The first policy also limited coverage for treatment of "psychiatric care" in

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[2]Respondent paid for coverage only up to the limit of the "mental illness" provisions which left an uncovered deficiency of over $55,000 in expenses that were the responsibility of petitioner to pay. The deficiency under the first policy was $31,240.38; under the second policy it was $24,672.49. App. B at A-13, 730 F. Supp. at 294.

the same provision that limited coverage for "mental illness."[3] The term "psychiatric care" was also left undefined. The district court found that under the first policy, Rob Brewer's receipt of "psychiatric care" was sufficient to come within the scope of the "mental illness" exclusion and therefore denied recovery under the first policy. App. B at A-18, 730 F. Supp. at 297.

The second policy again left "mental illness" undefined, and also lacked any reference to "psychiatric care."[4] The

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[3]The district court quoted the pertinent portions of the first policy as follows:

> *Mental Illness, Substance Abuse and Alcoholism*
> Charges for treatment of mental illness(es), functional nervous disorder(s) of any type or cause, substance abuse, alcoholism, or for psychiatric or psychoanalytic care for any reason are covered as follows: [limitations specifically set forth in policy omitted.]

App B. at A-10 to A-11, 730 F. Supp. at 293-94. The only definitions in the first policy stated that: "'Illness' or 'Sickness' means a bodily disorder or disease, pregnancy, mental infirmity or bodily injury." App. B at A-11, 730 F. Supp. at 294.

[4]The district court quoted the following pertinent portions of the second policy:

MAJOR MEDICAL LIMITATIONS

> The maximum payment for care of mental illness, nervous conditions of any type or cause, substance abuse or outpatient treatment of alcoholism, by a doctor will not be more than [limitations omitted.]

second policy's exclusion from "major medical" coverage applied to "care of *mental illness*, nervous conditions of any type or cause, substance abuse or outpatient treatment of alcoholism...." App. B at A-11 to A-12, 730 F. Supp. at 294 (emphasis added).

The district court found that ERISA did not provide assistance in interpreting the second policy's "mental illness" exclusion, and therefore referred to state law "for guidance in ascertaining the principles applicable to the ERISA action." App. B at A-17, 730 F. Supp. at 296. Finding the policy term ambiguous, the district court applied Missouri's contra insurer rule and ruled that the ambiguous coverage restriction for "mental illness" should be construed in favor of the insured and against the insurer. App. B at A-17 to A-21, 730 F. Supp. at 296-98. *But see* App. A at A-4 n.1, 921 F.2d at 153 n.1 ("We cannot tell whether or to what extent the contra insurer rule affected the district court's opinion....").

In construing the undefined policy term, "mental illness," in favor of the insured, the district court adopted a definition that included only behavioral disturbances with "no demonstrable organic or physical basis," and which stemmed "'from reaction to environmental conditions as distinguished from organic causes.'" App. B at A-19, 730 F. Supp. at 297 (quoting *Kunin v. Benefit Trust Life Ins. Co.*, 696 F. Supp.

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> For treatment of mental illness or substance abuse, charges are limited to [limitations omitted].

App. B at A-11 to A-12, 730 F. Supp. at 294. The second policy also included a maximum, aggregate lifetime benefit "for charges for mental illness(es), substance abuse or outpatient treatment of alcoholism. *Id.* This policy did define "illness" as "1. A disorder or disease of the body or mind; or 2. An accidental bodily injury; or 3. Pregnancy." *Id.*

1342, 1346-47 (C.D. Cal. 1988). Based on the definition adopted from ***Kunin*** and the reasoning therein, the district court concluded that bipolar affective mood disorder is not a "mental illness" within the meaning of respondent's insurance policy. The district court found that the

> evidence credibly establishe[d] that the severe disorder affecting Rob Brewer stemmed most probably from a chemical imbalance in his brain, rather than from environmental factors such as a traumatic experience or a parental relationship. While the disorder is described through its symptoms, that in and of itself does not render it a "mental illness" as defined by this Court.

App. B at A-20, 730 F. Supp. at 298.

*3. Proceedings in the Court of Appeals.* The Eighth Circuit reversed.[5] Finding that the district court erroneously concluded that the contra insurer rule applied, the Eighth Circuit held that Missouri's contra insurer rule "does not regulate insurance and is preempted by ERISA." App. A at A-3 to A-5, 921 F.2d at 153. As support for rejection of the contra insurer rule, the court of appeals relied upon this Court's admonition in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that disputed language be construed "without deferring to either party's interpretation." App. A at A-5 to A-6, 921 F.2d at 154.

After rejecting the Ninth Circuit's reasoning in *Kunin*, the guidance of state law and the contra insurer rule, the court of

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[5]The court of appeals affirmed the district court's denial of benefits with respect to the first policy, but based its affirmance on the policy's exclusion for "mental illness." The Eighth Circuit therefore did not address the district court's analysis of the term "psychiatric care." App. A at A-7 n.3, 921 F.2d at 154 n.3.

appeals fashioned its own federal common law principles for interpreting the term "mental illness." The court of appeals concluded that "[i]t would be improper and unfair to allow experts to define terms that were specifically written for and targeted toward laypersons." App. A at A-6, 921 F.2d at 154. In reversing the district court's decision that "mental illness" under the policy at issue was to be defined by its causes and not by its symptoms, the Eighth Circuit panel relied on its own conception of how laypersons understand the term "mental illness," and not on the evidence in the district court. App. A at A-6 to A-7, 921 F.2d at 154.

Because the policy did not specifically limit the definition of "mental illness" to "only those illnesses that have a non-organic origin," the court of appeals essentially concluded that the "mental illness" exclusion from coverage, though undefined, should be construed broadly. The court stated:

> By focusing upon the disease's etiology, the district court considered factors that are important to experts but not to laypersons. The court thus failed to examine the term "mental illness" as a layperson would have, which is the examination we conclude ERISA and federal common law require.

App. A at A-7, 921 F.2d at 154.

The court of appeals reached this conclusion notwithstanding a directly conflicting Ninth Circuit decision. App. A at A-6 n.2, 921 F.2d at 154 n.2. *See Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 539-40 (9th Cir.), *cert. denied*, 111 S. Ct. 581 (1990). "We expressly disagree with our sister court's conclusions and decline to follow *Kunin*." App. A at A-6 n.2, 921 F.2d at 154 n.2.

The issues in this case thus address the proper standard for interpretation of ambiguous terms in health benefit plans

governed by ERISA, when the insurance company that wrote the policy did not define the terms. In framing a rule of construction for ambiguous terms in ERISA plans, in this case the terms "mental illness" or "psychiatric care," the Eighth Circuit rejected the universally held rule that ambiguous terms in insurance policies should be construed in favor of the insured and against the insurer.

## REASONS FOR GRANTING THE WRIT

In direct conflict with the decision of another court of appeals, the Eighth Circuit rejected the contra insurer rule and *broadly construed ambiguous exclusionary limitations on coverage* in an ERISA welfare benefit plan to the detriment of plan participants and beneficiaries. The decision thwarts the express purpose of ERISA, as expressed by its statutory language and the decisions of this Court, and incorrectly decided questions of great importance to the administration of employee welfare benefit plans throughout this nation. If not reviewed and reversed by this Court, the standard for interpretation adopted by the Eighth Circuit, will frustrate the very purpose for the enactment of ERISA, i.e., the protection of employees and beneficiaries, while decreasing the responsibility of fiduciaries below that which they would otherwise have had under the law prior to the enactment of ERISA.

### I. This Case Involves Questions Of Great Importance To The Construction And Interpretation Of *All* ERISA Plans, Not Just Those Affecting The Several Million Persons Afflicted With Bipolar Affective Mood Disorder

The implications of this decision are significant. Limited to the facts of this case, the decision threatens the ability of several million Americans to obtain adequate treatment of a long misunderstood but now treatable, organically based,

physical disease that manifests itself with symptoms of mental disorder. "[T]ens of thousands of other policies issued as part of employee benefit plans [provide] lesser benefits for 'mental illnesses' than for other illnesses." Brief of Amicus Curiae Health Insurance Association of America at 2, *Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990) (hereinafter "Brief of Health Ins. Assn. of America"). In addition to the significance of this case to the large number of persons affected by its specific fact pattern, the legal principle has even broader importance.

By addressing the question of whether the contra insurer rule of every state and the District of Columbia is preempted by ERISA, and if so, by addressing whether the contra insurer rule should be incorporated into the federal common law of ERISA, the questions presented in this case have dramatic effects upon the interpretation and coverage of *all* employee welfare benefit plans throughout the nation. The Eighth Circuit decision extends far beyond the narrow issue of how to interpret the undefined term "mental illness." The Eighth Circuit's refusal to recognize the contra insurer rule's applicability to ERISA welfare benefit plans, whether by reference to state law or by incorporation into federal common law, contravenes ERISA's primary purpose -- the protection of employee benefit plan participants and beneficiaries. That aspect of the Eighth Circuit's decision extends the impact of its erroneous decision far beyond the several million persons affected with bipolar affective mood disorder. The decision threatens the benefits of every ERISA insurance plan participant and beneficiary in this country, because it involves a general rule of construction that is applicable to *all* ERISA insurance plans.

Despite the obvious importance of this case, petitioner acknowledges that respondent may oppose the issuance of a writ of certiorari given the outcome of the Eighth Circuit decision. Any opposition to certiorari by respondent more likely results not from a lack of importance of the issues, but

from a tactical desire to contest these controversies case by case -- against individual beneficiaries who, for either financial or health reasons, are ill equipped to litigate against giant insurance companies. This dispute is too important to be resolved by individual battles on such an uneven playing field. Accordingly, this Court should grant a writ of certiorari now and clarify the confusion arising from the conflict in the circuits on this important issue.

The Eighth Circuit decision attempted to ascertain an appropriate federal common law principle to aid in the interpretation of ERISA. In effect, the decision lessens the protections that formerly existed for participants and beneficiaries of group health insurance policies before passage of ERISA. In that respect the Eighth Circuit decision implicitly conflicts with the result in *Firestone Tire & Rubber Co. v. Bruch*, which declined to adopt a position which would give insurance policy beneficiaries less protection than they had before the enactment of ERISA. *See Bruch*, 489 U.S. 101, 113-14, 109 S. Ct. 948, 956 (1989).

Paradoxically, the Eighth Circuit cited *Bruch's* reference to the common law of trusts as an aid in interpreting ERISA. App. A at A-5 to A-6, 921 F.2d at 153-54 (citing *Bruch*, 489 U.S. at 114). The Eighth Circuit's analysis and application of the trust law analogy in *Bruch* is faulty for reasons set forth *infra*. To the extent that the issues of this case implicate trust law, the appropriate analogy would be to respondent as a plan fiduciary with a significant conflict of interest. The consequences of the Eighth Circuit's ill-advised decision are so significant that this Court should grant a writ of certiorari to correct the panel decision.

While it might be correct under *Bruch* for the Eighth Circuit to review the district court's conclusions *de novo*, the Eighth Circuit erred in failing to consider the relative position of the parties. In *Bruch* this Court specifically alluded to the

need to consider whether a plan administrator or fiduciary "is operating under a conflict of interest." *Bruch*, 489 U.S. at 115. Under accepted rules of trust law, a finding that a fiduciary has a conflict of interest "has a tremendous impact on the evaluation of the fiduciary's actions." *Brown v. Blue Cross & Blue Shield*, 898 F.2d 1556, 1565 (11th Cir. 1990), *cert. denied*, 111 S. Ct. 712 (1991).

Both *Bruch* and *Brown* addressed the differing standards that apply under ERISA when a fiduciary has a conflict of interest. The finding of a conflict of interest "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion'" by the fiduciary. *Bruch*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, Comment *d* (1959)). *See Brown*, 898 F.2d at 1562-68. *Brown* specifically identified and discussed the conflict of interest faced by an insurance company that "serves as the decisionmaking fiduciary for benefits that are paid out of the insurance company's assets." 898 F.2d at 1561.

> Decisions made by the issuing [insurance] company on behalf of a[n ERISA] plan based on a contract of insurance, by contrast, inherently implicate the hobgoblin of self-interest. Adverse benefits determinations save considerable sums that are returned to the fiduciary's corporate coffers. The presumption that the fiduciary is acting for the future stability of the fund cannot be entertained.

*Id.* at 1568.

The conflict of interest faced by an insurer making benefits determinations illustrates why courts uniformly construe ambiguous provisions of an insurance policy in favor of the insureds and against the insurer. Just as trust law principles shift the burden to a fiduciary with a conflict of interest, the contra insurer rule shifts the burden to the insurer

who has a similar conflict of interest when making benefit determinations that involve ambiguous terms in the insurer's own policy. The Eighth Circuit's rejection of this principle defies understanding, particularly in light of this Court's discussion of the distinctions between pension and welfare benefit plans under ERISA, and especially "insured plans." *See, e.g., Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985).

Accordingly, given the importance of establishing whether the contra insurer rule applies to ERISA insurance plans, this Court should grant a writ of certiorari.

## II. This Court Should Resolve The Conflict In The Circuits By Granting A Writ Of Certiorari To The Eighth Circuit.

This Court should also grant a writ of certiorari to end the confusion which exists as a result of the conflict between the Eighth Circuit's decision below and the Ninth Circuit's decision in *Kunin*. The confusion harms the insureds and their beneficiaries as well as the insurers who provide this kind of insurance. An amicus curiae in support of the respondent, the Health Insurance Association of America, argued the importance of *predictability* before the Eighth Circuit. "As with any form of insurance, a *predictable allocation of risk and costs*, based upon historical patterns of claim payments, *is essential* to the financial integrity of a finite fund subject to partial liquidation upon the occurrence of events, such as illness and disability." Brief of Health Ins. Assn. of America at 2 (emphasis added). To assure predictability in the administration of ERISA plans and to clarify the confusion arising from the conflict in the circuits, this Court should grant a writ of certiorari in this case.

## A. The Conflict Among The Circuits Requires Resolution By This Court Of Whether ERISA Preempts The Decisional Rule Of Construction In Every State And The District Of Columbia That Ambiguous Terms In An Insurance Policy Are Construed In Favor Of The Insured And Against The Insurer.

The Eighth Circuit's decision that ERISA preempts the contra insurer rule is in direct conflict with the Ninth Circuit's decision in *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 539–40 (9th Cir.), *cert. denied*, 111 S. Ct. 581 (1990). *See* App. A at A–6 n.2, 921 F.2d at 154 n.2 ("We expressly disagree with our sister court's conclusions and decline to follow *Kunin*.").

The Ninth Circuit acknowledged that ERISA controlled the interpretation of an employee welfare benefit plan, *Kunin*, 910 F.2d at 539, but noted that state law can control "either because Congress intends courts to look to state law, or because the incorporation of state law into the federal common law is 'appropriate as a matter of judicial policy.'" *Id.* (quoting *Mardan Corp. v. C.G.C. Music, Ltd.*, 804 F.2d 1454, 1458 (9th Cir. 1986)). According to the Ninth Circuit, the contra insurer rule was applicable, "regardless of whether it applies as a matter of uniform federal law or because federal law incorporates state law on this point." *Id.* at 540.

This Court has previously held that when Congress passed ERISA, it set out to "*'protect... participants in employee benefit plans and their beneficiaries....'*" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987) (emphasis added) (quoting 29 U.S.C. § 1001(b)). "ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). Moreover, this Court also stated that Congress' purpose in passing ERISA's preemption provisions, ERISA § 514, 88 Stat. 897, *codified*

*at*, 29 U.S.C. § 1144 (1986), was *to ensure uniformity in interpreting ERISA* -- so that employers would not face "the threat of *conflicting or inconsistent* State and local regulation of employee benefit plans." *Shaw*, 463 U.S. at 46 (quoting 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams)). Nevertheless, Congress also passed section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A) ("the saving clause"), which exempts from preemption and "preserves any state law 'which regulates insurance....'" *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (quoting the saving clause).

Looking to state law for guidance in interpreting ambiguous provisions of employee welfare benefit plans comports with the language and purpose of ERISA for two reasons. First, *every state and the District of Columbia employs the contra insurer rule* that ambiguities are construed in favor of the insured and against the insurer. *See Kunin*, 910 F.2d at 538-39 & n.6 (citing several treatises in support). Thus, given the states' unanimity in adopting the contra insurer rule, ERISA's goal of promoting uniformity is met. Likewise, the protective effect of the contra insurer rule furthers ERISA's goal of protecting plan participants and beneficiaries.

Second, ERISA's savings clause does not allow the preemption of "State law" that "regulates insurance." *See* 29 U.S.C. § 1144(b)(2)(A). As a *decisional* law, the contra insurer rule is a "State law" under ERISA, *id.* § 1144(c)(1), as used in both the preemption and savings clauses. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91-92 & n.6 (1983). As discussed *infra*, the contra insurer rule clearly "regulates insurance" under ERISA's savings clause and thus is not preempted. *See Met. Life v. Massachusetts*, 471 U.S. at 732.

Contrary to the Eighth Circuit's decision, the Ninth Circuit held that ERISA incorporates the state contra insurer rule. *See Kunin*, 910 F.2d at 540 (alternative holding). *See also id.* at 539 n.8 (discussing confusion of various courts on interpretation of ERISA's savings clause). In *Metropolitan Life Ins. Co. v. Massachusetts*, this Court quoted with approval an earlier case that stated that the "interpretation" of an insurance policy is at "'the core of the *business of insurance*.'" 471 U.S. at 744 (emphasis added) (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)). If *interpreting* the terms of an insurance policy is *at the core of the business of insurance*, then state rules of construction that dictate how to interpret an insurance policy must likewise be laws that "regulate insurance." Therefore, the states' contra insurer rule is not preempted under ERISA.

Petitioner contends that the Ninth Circuit correctly incorporated the state contra insurer rule into ERISA to assist in construing a group health insurance policy and correctly concluded that autism is not a "mental illness" under the applicable policy. *See Kunin*, 910 F.2d at 538. The Ninth Circuit accepted the same conclusion drawn by the district court in this case that "mental illness 'refers to a behavioral disturbance with no demonstrable organic or physical basis... [and] stems from reaction to environmental conditions as distinguished from organic causes.'" *Id.* (quoting decision below, 696 F. Supp. at 1346). *See* App. B at A-19, 730 F. Supp. at 297. In contrast, the Eighth Circuit concluded both that ERISA preempts the contra insurer rule and that "mental illness" should be construed broadly based on its manifested symptoms, rather than narrowly based on its cause. App. A at A-7, 921 F.2d at 154. *But see Arkansas Blue Cross & Blue Shield, Inc. v. Doe*, 22 Ark. App. 89, 93-94, 733 S.W.2d 429, 432 (1987) (en banc) (bipolar affective mood disorder is a physical, organically based disorder that is properly classified by cause, not symptoms and therefore is not a "mental illness" under health insurance policy

limitations). *Cf. Equitable Life Assur. Soc. v. Berry*, 212 Cal. App.3d 832, 837-41, 260 Cal. Rptr. 819, 822-24 (6th Dist. 1989) (recognizing that ambiguities in policy are construed against the insurer, but finding that specific policy language at issue, "mental disorder," was *unambiguous* and properly classified by symptoms rather than cause). *But Cf. Rosenthal v. Mutual Life Ins. Co.*, 732 F. Supp. 108, 110-11 (S.D. Fla. 1990) ("mental disorder" is *ambiguous* and "reasonable persons could find that Bipolar Affective Disorder is a physical illness which manifests itself through mental symptoms" and thus "mental disorder" is not limited by policy limitations clause).

Given the importance of this issue, this Court should resolve the conflict in the circuits by granting a writ of certiorari to the United States Court of Appeals for the Eighth Circuit.

**B. Even If The Contra Insurer Rule Were Preempted By ERISA, The Conflict Among The Circuits Requires Resolution By This Court Of Whether The Federal Common Law of ERISA Incorporates The Contra Insurer Rule That Ambiguous Insurance Policy Terms Are Construed In Favor Of The Insured And Against The Insurer.**

Even if ERISA preempts state laws mandating application of the contra insurer rule, a conflict in the circuits still exists. The Ninth Circuit decision in *Kunin* incorporated the rule into the federal common law of ERISA, 910 F.2d at 540, a decision which again conflicts directly with the Eighth Circuit's rejection of the rule. App. A at A-6 to A-7, 921 F.2d at 154. The Eighth Circuit's refusal to incorporate the contra insurer rule into the federal common law of ERISA conflicts with *Kunin* and the spirit and purpose of ERISA, as well. As previously noted, all fifty states and the District of Columbia employ the contra insurer rule. Even federal

admiralty law employs the contra insurer rule. *See Employers Ins. of Wausau v. Trotter Towing Corp.*, 834 F.2d 1206, 1210 (5th Cir. 1988). The uniformity that Congress sought to ensure with ERISA's preemption provision is destroyed by the Eighth Circuit decision in this case -- a decision which conflicts not only with the Ninth Circuit, but also conflicts with the interpretation of every state in the country as well. *See Kunin*, 910 F.2d at 538-39 & n.6, 540.

Moreover, in principle the Eighth Circuit decision conflicts with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. at 110-115. In support of its decision, the Eighth Circuit cited this Court's admonition in *Bruch* not to defer to either party's interpretation. App. A at A-5 to A-6, 921 F.2d at 153-54. Misconstruing that language in *Bruch*, the court of appeals held that ERISA not only preempted the contra insurer rule, but also required an opposite result -- construction of an ambiguous policy term in favor of the *insurer*! App. A at A-7, 921 F.2d at 154. This portion of the Eighth Circuit decision conflicts with the result in *Bruch* by lessening the protections of insured beneficiaries from that which they formerly had under the common law contra insurer rule. *See Bruch*, 489 U.S. at 113-14.

In *Bruch* this Court refused to adopt a reading of ERISA that "would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* Likewise, the Eighth Circuit should have been unwilling to reject a rule of construction that effectively diminished the protection afforded plan participants and beneficiaries from that which they enjoyed before passage of ERISA. The Ninth Circuit first contemplated the applicability of the contra insurer rule to ERISA and thought "it would take a certain degree of arrogance to controvert an opinion held with such unanimity in the various states and to adopt a contrary view

as the federal rule." *Kunin*, 910 F.2d at 540. Nevertheless, the Eighth Circuit expressly rejected the axiomatic and uniformly held view that ambiguous insurance policies drafted by the insurer are construed against the insurer and in favor of the insured.

The Eighth Circuit also rejected the contra insurer rule because it could be characterized as a rule of *contract* and not just *insurance* law. App. A at A-5, 921 F.2d at 153. The Eighth Circuit's decision ignores the fact that ERISA regulates a specific kind of *contract*; as this Court recognized in *Bruch*, courts construe ERISA plans as they do "*contractual* provisions" and "terms in trust *agreements*." *Bruch*, 489 U.S. at 112 (emphasis added). Furthermore, this Court also acknowledged that ERISA was enacted to promote the interests of employees and beneficiaries and "'to protect *contractually defined benefits.*'" 489 U.S. at 113 (emphasis added) (quoting *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)). Applying a specialized rule of *contract construction* to insurance *contracts* therefore makes eminent sense and, significantly, *was the common law rule prior to passage of ERISA*.

If the contra insurer rule was preempted under ERISA, petitioners respectfully submit that the purpose of ERISA and this Court's prior precedents support the conflicting Ninth Circuit opinion in *Kunin* and mandate that the contra insurer rule be incorporated into the federal common law of ERISA.

## CONCLUSION

For the foregoing reasons petitioners respectfully request that this Court grant a writ of certiorari to the United States Court of Appeals for the Eighth Circuit.

Dated this 1st day of May, 1991.

Respectfully submitted,

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# APPENDIX

## APPENDIX A

UNITED STATES COURT OF APPEALS
EIGHTH CIRCUIT

Nos. 90-1226EM, 90-1227EM

Robert P. Brewer, Natural Guardian
and Duly Appointed Next Friend of
Robert C. Brewer,
Appellee,

v.

Lincoln National Life Insurance Company,
Appellant.

Submitted Oct. 8, 1990

Decided Dec. 7, 1990

Clark Cole, St. Louis, Mo., for appellant.

Joseph F. Devereux, Jr., St. Louis, Mo., for appellee.

Before BOWMAN, Circuit Judge, FLOYD R. GIBSON, nior Circuit Judge, and WOLLMAN, Circuit Judge.

FLOYD R. GIBSON, Senior Circuit Judge.

Robert P. Brewer appeals the district court's termination that the care administered his son, Robert C. ewer, was "psychiatric care" and its refusal to award orney fees in his favor. Lincoln National Life Insurance mpany (hereinafter "Lincoln National") also appeals, llenging both the district court's determination that Robert Brewer was not hospitalized due to a "mental illness" and refusal to admit into evidence material contained in coln National's "Post-Trial Appendix." We reverse the

district court's conclusion that the son's affliction was not a "mental illness" and, consequently, obviate the need to address the other issues presented in this appeal.

## I. BACKGROUND

Robert P. Brewer participated in an employee welfare benefit plan provided by his employer, Missouri Encom, Inc. Health benefits under the plan were provided by Lincoln National.

Robert P. Brewer's son, Robert C. Brewer, was hospitalized on three occasions between October 1986 and October 1987. The hospitalization was prompted by a sharp decline in the son's grades, repeated incidents of lying, and other behavioral problems both in and out of school. T.Tr. 16–18. Brewer's son was diagnosed as suffering from affective mood disorder, and he was successfully treated with a combination of drugs and psychotherapy.

One insurance policy was in effect during the first two visits, and a second policy was in effect during the last visit. The first policy limited its coverage for hospital charges associated with "mental illness(es), functional nervous disorder(s)... or for psychiatric or psychoanalytic care" to a maximum of $50,000. The second policy had the same limit for charges associated with care of "mental illness(es)." Neither policy defined the phrase "mental illness." The first policy defined "illness" as "a bodily disorder or disease, pregnancy, mental infirmity or bodily injury," and the second policy contained a similar definition.

Claims were submitted to Lincoln National, which paid for the care in accordance with the policies' provisions regarding mental illnesses. A total of $55,912.87 was unpaid by Lincoln National; $31,240.38 due to the cap in the first policy and $24,672.49 due to the cap in the second policy.

It is undisputed that these charges would have been paid if the limitations on coverage did not apply.

At trial, the district court heard testimony from three doctors of varying specialties. The testimony indicated that the precise cause of the son's condition was unknown, but that mounting medical evidence suggested that affective mood disorder is genetically or biologically caused. T.Tr. at 47, 88–89. Based on the testimony, the district court concluded that the son did not suffer from a mental illness because a "'mental illness stems from reaction to environmental conditions as distinguished from organic causes'" and that "'mental illness is often thought by lay persons as having nonphysical, psychological causes, in the Freudian sense, as opposed to an organic basis.'" *Brewer v. Lincoln Nat'l Life Ins. Co.*, 730 F. Supp. 292, 297 (E.D. Mo. 1989) (quoting *Kunin v. Benefit Trust Life Ins. Co.*, 696 F. Supp. 1342, 1346, 1347 (C.D. Cal. 1988), *aff'd*, 910 F.2d 534 (9th Cir. 1990)). The district court also determined that the treatment was psychiatric care because it was "'the sort of treatment, such as electroshock therapy and psychotropic medication, rendered to a patient who has been admitted to a psychiatric ward in order to attend to his or her psychiatric disorder.'" *Id.* (quoting *Simons v. Blue Cross & Blue Shield of Greater New York*, 144 A.D.2d 28, 33, 536 N.Y.S.2d 431, 434 (1989)). Consequently, the court ruled that Lincoln National properly denied coverage under the first policy because coverage was limited as to "psychiatric care" but that coverage was improperly denied under the second policy because there was no cap on psychiatric care and the son did not suffer from a mental illness.

## II. DISCUSSION

Initially, we must determine whether the district court properly utilized Missouri's rule construction requiring that ambiguities in insurance contracts be resolved in favor of the

insured (the "contra insurer rule").[1] While it is true that state law can be used as a guide for fashioning the federal common law applicable to ERISA, *Lyman Lumber Co. v. Hill*, 877 F.2d 692, 693 (8th Cir. 1989), state law cannot be used if it is contrary to the provisions of ERISA. *Rockney v. Blohorn*, 877 F.2d 637, 643–44 (8th Cir. 1989). We conclude that this state law rule of construction violates the provisions of ERISA and thus cannot be used to interpret the plan's terms.

ERISA is a broad, comprehensive regulation that preempts state laws relating to employee benefit plans, 29 U.S.C. § 1144(a), unless the state law in question "regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A). The preemption clause applies broadly to all state laws that have any direct or indirect relation to pension plans even if they were not designed specifically for that purpose. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–98, 103 S.Ct. 2890, 2899–2901, 77 L.Ed.2d 490 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525, 101 S.Ct. 1895, 1907, 68

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[1]While the district court did state that it would "review the terms of the plans without giving deference to either side's position," *Brewer*, 730 F. Supp. at 296, the court also determined that state law could be used as a guide in interpreting the policies. To that end, the court referred to Missouri cases holding that "[p]rovisions restricting coverage are construed in favor of the insured and against the insurer," *id.* (citing *Citizens Ins. Co. of N.J. v. Kansas City Commercial Cartage, Inc.*, 611 S.W.2d 302, 307 (Mo.Ct.App.1980) (per curiam)), and that ambiguities should be "resolved in favor of the insured." *Id.* at 296–97 (citing *Robin v. Blue Cross Hosp. Serv., Inc.*, 637 S.W.2d 695, 698 (Mo. 1982) (en banc)). We cannot tell whether or to what extent the contra insurer rule affected the district court's opinion, and are compelled to address the issue because of this uncertainty.

L.Ed.2d 402 (1981). However, a state law is not preempted if it regulates insurance; that is, if it "has the effect of transferring or spreading a policyholder's risk, ... is an integral part of the policy relationship between the insurer and the insured, and ... the practice is limited to entities within the insurance industry.'" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49, 107 S.Ct. 1549, 1553-54, 95 L.Ed.2d 39 (1987) (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009, 73 L.Ed.2d 647 (1982)).

Missouri's rule of construction clearly affects pension plans. However, it does not regulate the insurance industry. We agree with the Sixth Circuit that the contra insurer rule is a "general principle of contract construction [that] does not effect a spreading or transferring of policyholders' insurance risk, but rather forces the insurer to bear the legal risks associated with ambiguous policy language." *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 429 (6th Cir. 1989). Furthermore, this rule of construction is nothing more than a specific application of general state contract principles and was not specifically designed for the insurance industry. *E.g., Shelter Mut. Ins. Co. v. Haller*, 793 S.W.2d 391, 393 (Mo.Ct.App. 1990); *Farm Bureau Mut. Ins. Co. v. Broadie*, 558 S.W.2d 751, 755 (Mo.Ct.App. 1977); *see also McMahan*, 888 F.2d at 429 (discussing Kentucky law). Consequently, the contra insurer rule does not regulate insurance and is preempted by ERISA.

Our conclusion is further supported by the Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). There, the Supreme Court injected principles of trust law into ERISA and decided that a denial of benefits was to be reviewed de novo unless the plan specifically granted the plan administrator discretion to determine eligibility. *Id.* at 114, 109 S.Ct. at 956. We have previously interpreted *Bruch* to mean that "unless the plan language specifies otherwise,

courts should construe any disputed language 'without deferring to *either* party's interpretation.'" *Wallace v. Firestone Tire & Rubber Co.*, 882 F.2d 1327, 1329 (8th Cir. 1989) (quoting *Bruch*, 489 U.S. at 112, 109 S.Ct. at 955) (emphasis added).[2]

Having determined that neither party's construction should be favored, we still must decide how the phrase "mental illness" is defined. ERISA does not provide an express answer, so we must "ascertain the proper federal common law principles that should govern." *Lyman Lumber*, 877 F.2d at 693. And, while "fashioning a body of federal common law, we may look to state law for guidance." *Id.*, as noted above, state law is an inappropriate guide in this situation. Consequently, we look elsewhere, first at ERISA itself.

Lincoln National was required to furnish plan descriptions "written in a manner calculated to be understood by the average plan participant...." 29 U.S.C. § 1022(a)(1). It would be improper and unfair to allow experts to define terms that were specifically written for and targeted toward laypersons. This requirement provides a source from which we may fashion a federal common law rule; the terms should be accorded their ordinary, and not specialized, meanings.

The cause of a disease is a judgment for experts, while laymen know and understand symptoms. Laymen undoubtedly are aware that some mental illnesses are organically caused while others are not; however, they do not classify illnesses based on their origins. Instead, laypersons

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[2]The Ninth Circuit recently addressed both this argument and the preemption argument and reached results contrary to those we reach today. *See Kunin*, 910 F.2d at 538-41. We expressly disagree with our sister court's conclusions and decline to follow *Kunin*.

are inclined to focus on the symptoms of an illness; illnesses whose primary symptoms are depression, mood swings and unusual behavior are commonly characterized as mental illnesses regardless of their cause.

Neither policy in this case limited the definition of "mental illness" to only those illnesses that have a non-organic origin, and the district court should not have adopted a definition that effectively imposed such a limitation. By focusing upon the disease's etiology, the district court considered factors that are important to experts but not to laypersons. The court thus failed to examine the term "mental illness" as a layperson would have, which is the examination we conclude ERISA and federal common law require.

## III. CONCLUSION

Robert C. Brewer's disease manifested itself in terms of mood swings and aberrant behavior. Regardless of the cause of his disorder, it is abundantly clear that he suffered from what laypersons would consider to be a "mental illness." Consequently, Lincoln National properly limited its coverage under both policies.[3] For these reasons, the district court's order is affirmed as to the first policy and reversed as to the second.

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[3]Because both policies limited coverage for mental illnesses, we do not need to decide whether the district court properly characterized the treatment as "psychiatric care." There is also no need to review either the exclusion of Lincoln National's "Post-Trial Appendix" or the denial of Brewer's attorney fees.

## APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 88-1987C(3)

ROBERT P. BREWER, Natural Guardian and
Duly Appointed Next Friend of
ROBERT C. BREWER,
Plaintiffs,

v.

Lincoln National Life Insurance Company,
Defendant.

## MEMORANDUM

This matter is before the Court to determine the merits of plaintiffs' claims after a one day bench trial.

Pursuant to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, et seq., plaintiffs seek equitable relief,[1] $55,912.87 in damages, interest, attorney's

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[1]Pursuant to 29 U.S.C. § 1132(3), plaintiffs seek declarations

> that affective mood disorder is a physical ailment for which defendant is obligated to pay benefits in accordance with its policy[;] . . . that the refusal of defendant to pay medical expenses incurred by plaintiff[s] for treatment of affective mood disorder

fees, and costs for defendant's allegedly improper failure to pay benefits under health insurance policies issued by defendant pursuant to an employee health plan provided by plaintiff Robert P. Brewer's employer. Defendant asserts that it is not liable for the payment of any additional expenses incurred during the relevant hospitalizations. In particular, the parties dispute whether charges for in-hospital care of severe affective mood disorder fall under the broad major medical benefits provision of the policies.

Having fully considered the pleadings, depositions, stipulations, evidence, and the entire record herein, the Court makes and enters the following findings of fact and conclusions of law.

*Findings of Fact*

1. Plaintiff Robert P. Brewer ("Robert Brewer") at all times material herein was a citizen of the State of Missouri and the County of St. Louis. Robert Brewer is the father, natural guardian, and duly appointed next friend of plaintiff

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> was a breach of fiduciary duty, unlawful and vexatious[;] . . . [and] that by the terms of the policy of insurance and pursuant to 29 U.S.C. § 1132, plaintiff[s are] entitled to coverage under said policy in the amount of $1,000,000 for any medical expenses arising in connection with any treatment rendered to plaintiff [Robert C. Brewer] for affective mood disorder.

Plaintiffs also seek an order permanently enjoining defendant "from denying plaintiff[s'] claim for benefits arising in connection with any treatment rendered to plaintiff [Robert C. Brewer] for affective mood disorder."

Robert C. Brewer ("Rob Brewer"), a minor and a dependent of Robert Brewer.

2. Defendant Lincoln National Life Insurance Company ("Lincoln") at all times material herein was a corporation duly existing under and by virtue of the laws of the State of Indiana, with its principal place of business in the State of Indiana, and is authorized to conduct business in the State of Missouri.

3. At all relevant times, plaintiffs were covered by an insurance plan provided by Robert Brewer's employer under which group health insurance policies were issued and administered by defendant Lincoln. In January 1988, defendant Lincoln stopped providing health insurance for Robert Brewer's employer.

4. The relevant insurance policies provide liberal benefits for charges by a hospital for board and room, medical services and supplies, and fees of legally qualified physicians and surgeons for medical care or treatment ("major medical expense provisions"). The policies also provide only limited coverage for charges for treatment of mental illness and of functional nervous disorders or nervous conditions of any type or cause ("mental illness provisions"). The first insurance policy also provides that charges for "psychiatric or psychoanalytic care for any reason" are encompassed by the mental illness provision.

5. The parties stipulated that the disputed charges would fall within and be fully paid under the major medical expense provisions of the policies were it not for the limitations of the mental illness provisions.

6. The mental illness provision in the first relevant insurance policy states:

> *Mental Illness, Substance Abuse and Alcoholism*
> Charges for treatment of mental illness(es), functional nervous disorder(s) of any type or cause, substance abuse, alcoholism, or for psychiatric or psychoanalytic care for any reason are covered as follows:
>
> 1. hospital charges for a maximum of 40 days of confinement in any one calendar year, and
>
> 2. charges by a legally qualified physician to a maximum payment of $30 per visit, limited to a maximum payment of $3,000 in any one calendar year.
>
> (The word "VISIT" includes each attendance of the physician to the patient, regardless of the type of professional services rendered, whether it might be otherwise termed consultation, treatment, or described in some other manner.)

That policy also provides that there is a "$50,000 maximum with respect to charges in connection with mental illness and substance abuse." The only definition in this policy states that:

> "Illness" or "Sickness" means a bodily disorder or disease, pregnancy, mental infirmity or bodily injury.

Otherwise, this policy does not contain a specific definition of "mental illness" or of "psychiatric care." Nor does this policy incorporate or adopt any other references to define those terms.

7. The mental illness provisions in the second relevant insurance policy provide as follows:

MAJOR MEDICAL LIMITATIONS

The maximum payment for care of mental illness, nervous conditions of any type or cause, substance abuse or outpatient treatment of alcoholism, by a doctor will not be more than $30.00 for each visit with a maximum of $3,000 in any one calendar year.

(A "Visit" occurs each time the doctor provides care to the patient.)

Maximum Covered Charge for Room and Board

* * *

For treatment of mental illness or substance abuse, charges are limited to a maximum of 40 days of hospital confinement in any one calendar year.

The policy also states that there is a $50,000 maximum (lifetime aggregate) benefit "for charges for mental illness(es), substance abuse or outpatient treatment of alcoholism."

This policy, unlike the earlier policy, contains a section on definitions. This section defines "illness" as "1. A disorder or disease of the body or mind; or 2. An accidental bodily injury; or 3. Pregnancy." This section does not contain a definition for "mental illness" or for "nervous conditions of any type or cause." Nor does this policy incorporate or adopt any other references to define those terms.

8. Rob Brewer was hospitalized on three separate occasions. The first hospitalization took place on October 6, 1986, and lasted until December 22, 1986. The second hospitalization began on January 28, 1987, and lasted until

April 4, 1987. The third hospitalization began on August 1, 1987, and lasted until October 9, 1987.

9. During each hospitalization, Rob Brewer was treated based upon diagnoses of severe affective mood disorder. His primary physician during these hospitalizations was Felix LaRocca, M.D., a psychiatrist who is board certified in psychiatry and child psychiatry. The care included the administration and monitoring of prescription medications (lithium bicarbonate and Nardil) along with psychotherapy sessions and meetings with the family.

10. The charges for these hospitalizations were paid in full to the extent permitted by the mental illness provisions of the insurance policies. The parties agree that the hospital and doctor bills for Rob Brewer's treatment during the hospitalizations at issue here are reasonable and that the treatment rendered was reasonably necessary to treat Rob Brewer's condition.

11. The charges not paid by defendant total $55,912.87, with $31,240.38 of that amount falling within the provisions of the first insurance policy, and $24,672.49 of that amount falling within the provisions of the second insurance policy. The disputed charges are for Dr. LaRocca's services, the psychiatric unit at the hospital, medications administered by Dr. LaRocca, and the psychologist's services.

12. Dr. LaRocca described Rob Brewer's diagnosed disorder as a hereditary disease characterized by a disturbance of catecholamines in the brain which produces a symptom of depression in some cases such as this one. While Dr. LaRocca characterized the etiology of this disorder as "uncertain," he stated it was possibly a derangement of neurotransmitters in the brain.

13. Dr. LaRocca reported the treatment for such a disorder is primarily medication and secondary

psychotherapy. This was the treatment provided to Rob Brewer and is considered by Dr. LaRocca to be "psychiatric treatment."

14. Dr. LaRocca consistently espouses the position that insurance companies should not differentiate in coverage between certain psychiatric care expenses and other major medical expenses. Although he had not read the language of the insurance policies at issue here, Dr. LaRocca opined that "affective mood disorder is not a mental illness or functional nervous disorder within the meaning of the exclusion set forth in the [relevant] group insurance plan." While these matters detract from the weight to be given Dr. LaRocca's testimony with respect to whether or not the charges at issue here are covered by the relevant insurance policies, they do not detract from the weight to be accorded his expert testimony regarding the basis of the disease and the treatment given to Rob Brewer.

15. Duane Hagen, M.D., a psychiatrist who is board certified in psychiatry, acknowledged that the precise etiology for mood disorders, such as those Rob Brewer had, is unknown but is increasingly being shown as having a biological or genetic basis. These mood disorders encompass severe mood changes where the person is unable to think or concentrate, has thoughts of suicide, and has negative thoughts. Treatment of severe mood disorders includes the use of antidepressant and other mood-stabilizing medications, as well as electro-convulsive therapy, if deemed appropriate.

16. To Dr. Hagen, the phrase "mental illness" encompasses any kind of emotional upset or distress including disorders.

17. Upon analysis of the available records, and without examining Rob Brewer personally, Dr. Hagen opined that Rob Brewer had a primarily depressive or unipolar mood disorder that was treated properly and reasonably. To Dr.

Hagen, the treatment provided to Rob Brewer was "psychiatric treatment" which has as its essence the proper diagnosis and use of medications along with adjunctive counselling.

18. Thomas Harris, M.D., a psychiatrist who is board certified in psychiatry, described affective mood disorders as having symptoms which affect a person's behavior, mood, and thinking processes, and as having, in some instances, an origin in inherited biological abnormalities. Dr. Harris included bipolar disorders, schizo-affective disorders, and major severe depressive disorders as in the latter group. Based on the available records and without personally examining Rob Brewer, Dr. Harris opined that Rob Brewer had a severe mood disorder which was an inherited vulnerability that caused problems through "abnormalities in brain and body chemistry and physiology, and which [has] secondary psychological and behavioral symptoms." Thus, Dr. Harris concluded Rob Brewer had a biological, rather than a mental, illness, although he did not clearly define "mental illness."

19. Dr. Harris distinguished the treatment for these illnesses as follows:

> The primary type of treatment that works for mental disorders is... some form of relearning experience.
>
> For biological disorders, it's important to stabilize the biological abnormality and this requires, generally, biological treatment.

Here, Dr. Harris noted, the primary course of treatment was the use of medications to stabilize Rob Brewer's "abnormal mood state and his marked and severe mood changes." Then, Dr. Harris acknowledged, psychotherapy group interaction, family involvement, and psychosocial therapies were used to assist the effectiveness of the medicinal treatment. For Dr.

Harris, the professional change in treatment methods, from primarily psychotherapeutic to primarily biological (such as medicines and electroconvulsive therapy) interventions reflects the presently accepted concept that these disorders have a biological basis, despite the fact the precise origin is not yet known. Dr. Harris further noted that counselling is provided to patients with diabetes and other chronic illnesses.

20. There is no evidence of record that Rob Brewer's disorder stemmed from a traumatic experience or from a parental relationship.

21. Thus, the available expert testimony establishes there is a biological basis for the disorder affecting Rob Brewer, even though the exact etiology of the disorder is not yet known.

22. On November 24, 1987, defendant denied plaintiffs' request for coverage of the expenses incurred during the third hospitalization.

*Conclusions of Law*

A. This Court has jurisdiction over the parties and subject matter of this action pursuant to 28 U.S.C. § 1332 and 29 U.S.C. § 1132(f).

B. Venue before this Court is appropriate pursuant to 29 U.S.C. § 1132(e)(2).

C. The insurance policies at issue here are "employee welfare benefit plans" pursuant to 29 U.S.C. § 1002(1)(A).

D. Plaintiffs are participant in and beneficiaries of the plans at issue here. 29 U.S.C. § 1002(7) and § 1002(8).

E. In relevant part, the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, et seq., provides

that "[a] civil action may be brought... by a [plan] participant or beneficiary... to recover benefits due... under the terms of [the] plan, to enforce... rights under the terms of the plan, or to clarify... rights to future benefits under the terms of the plan[.]" 29 U.S.C. § 1132(a)(1)(B). In such actions, actions like this one, "a denial of benefits... is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co v. Bruch*, 109 S. Ct. 948, 956 (1989). Under this standard, the Court construes the terms of the plan "without deferring to either party's interpretation." *Id.* at 955.

Here, there is no contention that the relevant plan gives defendant discretionary authority to determine eligibility for benefits or to construe the terms of the plans. Accordingly, the Court will review the terms of the plans without giving deference to either side's position.

F. Where, as here, none of ERISA's provisions addresses the issues presented in the case, state law may be used for guidance in ascertaining the principles applicable to the ERISA action. *Lyman Lumber Co. v. Hill*, 877 F.2d 692, 693 (8th Cir. 1989) (court may look to state law to fashion federal common law principles applicable to an ERISA case); *Rockney v. Blohorn*, 877 F.2d 637, 643-44 (8th Cir. 1989) (court may look to appropriate state contract law to govern the interpretation and enforcement of employer benefit plans so long as application of that law would not be contrary to ERISA's provisions).

G. Here, there is no dispute that the contested charges would be covered by and fully paid under the major medical expense provisions of the relevant policies if the limitations of the policies' mental illness provisions did not exist. Thus, the issue is whether or not the policies' mental illness provisions apply to the disputed charges. Provisions

restricting coverage are construed in favor of the insured and against the insurer, who has the burden of clearly and unambiguously expressing its intent to exclude. *Citizens Ins. Co. v. Kansas City Commercial Cartage, Inc.*, 611 S.W.2d 302, 307 (Mo. App. 1980) (per curiam). Plain and unambiguous language in an insurance contract must be given its plain meaning. *Howard v. Russell Stover Candies, Inc.*, 649 F.2d 620, 623 (8th Cir. 1981) (applying Missouri law). Any ambiguity is resolved in favor of the insured. *Robin v. Blue Cross Hosp. Serv., Inc.*, 637 S.W.2d 695, 698 (Mo. 1982) (en banc). Policy language is ambiguous if it is reasonably open to different construction. *Id.* Finally, the policy language must be viewed in light of the meaning understood by the lay person who obtained the policy. *Id.*

H. Upon consideration of the mental illness exclusionary language in the policy applicable to the first two hospitalizations, the Court is persuaded that the disputed charges (totalling $31,240.38) fall within the exclusion as "[c]harges for... psychiatric... care for any reason." Whether the Court relies on the credible expert testimony, which characterized the care given to Rob Brewer as "psychiatric care," or looks for the plain and ordinary meaning of that phrase, the result is the same. In *Simons v. Blue Cross & Blue Shield*, 144 A.D.2d 28, 536 N.Y.S.2d 431 (1989), the New York Supreme Court, Appellate Division, found that "[t]he plain, ordinary meaning of 'psychiatric' care is the sort of treatment, such as electroshock therapy and psychotropic medication, rendered to a patient who has been admitted to a psychiatric ward in order to attend to his or her psychiatric disorder." *Id.* at 434. This Court concurs with that New York court's assessment of "psychiatric care."

Accordingly, the Court finds defendant properly denied payment of $31,240.38 in charges incurred for the first two hospitalizations at issue here.

I. The "psychiatric care" language is not in the second policy which covered the third hospitalization. With respect to the disputed charges (totalling $24,672.49) incurred during the third hospitalization, defendant relies on the policy language which excludes "[c]harges for treatment of mental illness(es)."

J. The relevant definition in the policy, the definition of illness, only serves to render more ambiguous the phrase "mental illness" since the definition itself encompasses "mental infirmity." Thus, in and of itself, the insurance policy does not shed light on the interpretation of this phrase.

K. The record does not provide an expert's definition of the phrase "mental illness." Indeed, one expert opined the phrase encompasses any type of emotional distress. Such a description does not serve to clarify the phrase.

L. Moreover, the Court deems it appropriate to ascertain the ordinary meaning a lay person would give to the phrase. *Kunin v. Benefit Trust Life Ins. Co.*, 696 F. Supp. 1342, 1345 (C.D. Calif. 1988).

M. Having carefully considered the matter, the Court adopts the definition derived by the court in *Kunin, supra*. In that case, the court decided that an insurer's inclusion of "autism" within the limitation clause covering "mental illness" was not a reasonable interpretation of the policy and plan. *Id.* at 1347. In coming to this conclusion, the court adopted a definition of "mental illness" as an illness that "refers to a behavioral disturbance with no demonstrable organic or physical basis.... [A] mental illness stems from reaction to environmental conditions as distinguished from organic causes." *Id.* at 1346, 1346-47. The evidence in *Kunin* established that autism is one of the "pervasive developmental disorders... defined by its symptoms" and having an unknown etiology, with "medical research [showing] increasingly strong

evidence of a demonstrable organic basis for the syndrome." *Id.* at 1343, 1344. Noting that

> [if] the general nature of the cause of an illness is known and the cause is organic, the illness should not be encompassed within the term "mental illness" merely because of a lack of precision in the understanding of its causation[.]... [The court found that] mental illness is often thought of by lay persons as having nonphysical, psychological causes, in the Freudian sense, as opposed to an organic basis. Where dysfunctions of the brain derive from an identifiable organic basis, as in the case of brain cancer or Alzheimer's disease, the condition would not commonly be understood as mental illness. A related factor which can distinguish mental illnesses is their causation by environmental factors, such as traumatic experiences or childhood relationships.

*Id.* at 1346, 1347.

N. This Court finds the *Kunin* court's reasoning persuasive and, based upon that reasoning, determines the severe disorder at issue here is not a "mental illness" within the meaning of the second policy issued by defendant. Here, the evidence credibly establishes that the severe disorder affecting Rob Brewer stemmed most probably from a chemical imbalance in his brain, rather than from environmental factors such as a traumatic experience or a parental relationship. While the disorder is described through its symptoms, that in and of itself does not render it a "mental illness" as defined by this Court. Additionally, Rob Brewer was successfully treated with a regimen focused mainly on prescription medications. The secondary use of counselling to assist with Rob Brewer's adaptation to and recovery from the disorder does not take the malady within the realm of "mental illness." As Dr. Harris noted, counselling is used

regularly to assist patients with diabetes and other chronic diseases.

0. Accordingly, the Court finds it was improper for defendant to deny coverage of the expenses incurred during Rob Brewer's third hospitalization. Thus, the Court will award judgment in favor of plaintiffs and against defendant in the total amount of $24,672.49 for improperly denied benefits, plus post-judgment interest at the statutory rate.

P. The parties' requests for attorneys' fees and costs will be taken up by separate order.

Q. Defendant no longer being the health insurance carrier for the plan provided by Robert Brewer's employer, and finding no evidence to support the additional relief requested, the Court will deny plaintiffs' other requests for relief.

Dated this 6th day of October, 1989.

/s/William L. Hungate
UNITED STATES DISTRICT JUDGE

## APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 88-1987C(3)

Robert P. Brewer, Natural Guardian and
Duly Appointed Next Friend of
Robert C. Brewer,
Plaintiffs,

v.

Lincoln National Life Insurance Company,
Defendant.

## ORDER

A memorandum dated this day is hereby incorporated into and made a part of this order.

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that plaintiffs Robert P. Brewer and Robert C. Brewer recover from defendant Lincoln National Life Insurance Company a total of $24,672.49 in principal and postjudgment interest at the statutory rate, plus attorney's fees and costs to be decided during the course of subsequent proceedings.

Dated this 6th day of October, 1989.

/s/William L. Hungate
UNITED STATES DISTRICT JUDGE

## APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 88-1987C(3)

Robert P. Brewer, Natural Guardian and
Duly Appointed Next Friend of
Robert C. Brewer,
Plaintiffs,

v.

Lincoln National Life Insurance Company,
Defendant.

## ORDER

This matter is before the Court on plaintiff's motion to strike defendant's post-trial appendix. Defendant opposes the motion and alternatively asks the Court to take judicial notice of the materials contained in the disputed appendix.

Upon careful consideration,

IT IS HEREBY ORDERED that plaintiffs' motion to strike is granted.

IT IS HEREBY FURTHER ORDERED that defendant's alternative request to take judicial notice is granted in part as to Mo. Rev. Stat. §§ 376.381 and 376.382; and is otherwise denied.

Dated this 6th day of October, 1989.

/s/William L. Hungate
UNITED STATES DISTRICT JUDGE

## APPENDIX E

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 88-1987C(3)

Robert P. Brewer,
Plaintiff,

v.

Lincoln National Life Insurance Company,
Defendant.

## ORDER

This matter is before the Court on plaintiff's motion to alter or amend this Court's judgment by granting prejudgment interest. Defendant concurs that plaintiff is entitled to prejudgment interest and states "the judgment should be amended as proposed by plaintiff."

Upon consideration,

IT IS HEREBY ORDERED that plaintiff's motion is granted and the judgment dated October 6, 1989, is altered only so as to change the total amount to $28,691.70 (principal and prejudgment interest) as suggested by plaintiff. In all other respects, the judgment remains in full force and effect.

Plaintiff's request for attorney's fees and expenses remains before the Court.

/s/William L. Hungate
UNITED STATES DISTRICT JUDGE

Dated: 11/20/89

## APPENDIX F

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 88-1987C(3)

Robert P. Brewer, et al.,
Plaintiffs,

v.

Lincoln National Life Insurance Company,
Defendant.

## ORDER

A memorandum dated this day is hereby incorporated into and made a part of this order.

IT IS HEREBY ORDERED that plaintiffs' request for an award of attorneys' fees is denied.

IT IS HEREBY FURTHER ORDERED that plaintiffs' request for an award of costs is granted in part and denied in part so that a total of $1,929.61 in costs is taxed in favor of plaintiffs.

/s/William L. Hungate
UNITED STATES DISTRICT JUDGE

Dated: 2/15/90